

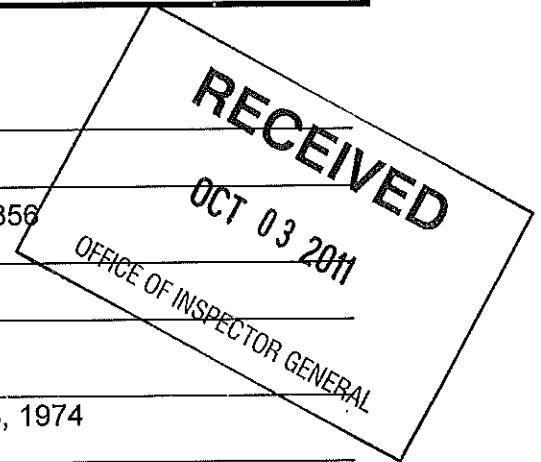
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 10/3/11
Amount 1095.00

52785

I. IDENTIFICATION

Name ROYAL MANOR, INC.
100 SPARKS AVE
 Address NICHOLASVILLE, JESSAMINE, 40356
 City/County/Zip 859-885-4171
 Telephone number BENJAMIN SPARKS
 Administrator MAY 8, 1974
 Date facility operation began at current address MAY 8, 1974
 Date facility began operation under current owner _____



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	<u>73</u>	<u>73</u>
Nursing Facility	_____	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/> X	Individual
County	Nonprofit	Partnership
City		Corporation <input checked="" type="checkbox"/> X
Private <input checked="" type="checkbox"/> X		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

JULIAN M SPARKS ESTATE P.O. BOX 565 GREENVILLE, KY 42345

GREGORY S SPARKS P.O. BOX 565 GREENVILLE, KY 42345

(OVER)

10/31

If facility owned or leased by a corporation, complete the following:

Name of corporation ROYAL MANOR, INC.
Address of corporation 100 SPARKS AVE NICHOLASVILLE, KY 40356
President or Chairman GREGORY S SPARKS
BEAU S SPARKS
Vice President _____
MURIEL MCROY
Secretary _____
MURIEL MCROY
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

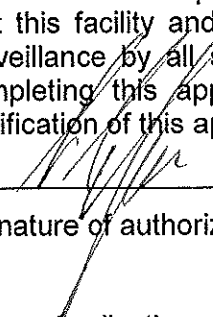
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.


Signature of authorized representative

President
Title

9-28-11
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)